SUPPLEMENT F
TECHNOLOGIST FLUOROSCOPY PERMIT APPLICATION SUPPLEMENT

(Summary of radiologic technology education and training in the use of fluoroscopy equipment)

Name (last) (first) (middle)

California Diagnostic Radiologic Technology Certificate number: _____

(You must have, or be in the process of receiving, a valid California Diagnostic Radiologic Technology Certificate in order to be eligible for admittance to the Fluoroscopy Permit Examination.)

Classroom instruction shall have included at least the following:

1. Fluoroscopy regulations and radiation safety (account for at least 10 hours).
2. Fluoroscopy equipment (account for at least 5 hours).
3. X-ray image intensifiers (account for at least 4 hours).
4. Television, including closed circuit equipment (account for at least 4 hours).
5. Image recording equipment (account for at least 6 hours).
6. Special fluoroscopy equipment (account for at least 5 hours).
7. Mobile image intensified units (account for at least 2 hours).
8. Anatomy and physiology of the eye (account for at least 2 hours).
9. Three dimensional and radiological anatomy (account for at least 2 hours).

Laboratory instruction shall have included at least 15 hours in which each student shall have conducted experiments on phantoms to illustrate at least the following:

1. Methods of reducing dose/exposure to the patient during fluoroscopy procedures.
2. Methods of reducing exposure to self and personnel.
3. Image recording during the exposure of a phantom.
4. Quality control of fluoroscopy equipment.

Attestation: I hereby attest that to the best of my knowledge, the above is true and accurate.

Applicant signature: _____ Date: _____

STATEMENT OF COMPETENCY

(To be completed by the applicant's radiologist.)

Supervising radiologist's name (print): _____

California Radiology Supervisor and Operator Certificate number, if applicable: _____ Expiration date: _____

Supervising Radiologists Statement:

I hereby attest that the following applicant has successfully completed supervised competency-based clinical education and training.

Signature of supervising radiologist: _____

Medical license number: _____ State: _____

Address: _____ City: _____ State: _____ ZIP code: _____

FOR DEPARTMENT OF HEALTH SERVICES USE ONLY

Approved by: _____ Date: _____

Approval denied by: _____ Date: _____

Reason for denial: _____